

# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Diat. No. 252

### 1. PLACE OF DEATH:

County Prince Anne

City or town Cherryville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? one life

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

### 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne

City or town Cherryville ne. Centerville  
(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_  
(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

### 3.(a) FULL NAME

Ann Barrett

### 3.(b) Social Security Number

4. Sex F. 5. Color or race W. 6.(a) Single, married, widowed, or divorced Widowed

6.(b) Name of husband or wife David Barrett

7. Birth date of deceased (mo., day, yr.) Mar. 11, 1857

8. AGE: Years 90 Months 5 Days 14 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.

9. Birthplace Cherryville, Md.  
(Town, county, and state)

10. Usual occupation Hom.

11. Industry or business \_\_\_\_\_

12. Name Ann Barrett

13. Birthplace \_\_\_\_\_

14. Maiden name Norris Bayes

15. Birthplace Md.

16. Informant Emory Kirby

Address Cherryville

17. Burial Date thereof 8 18 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Cherryville

Location Md.

18. Funeral director Cherryville, Md.

Address Cherryville, Md.

19. Aug 18 - 19 47 Elie Armatous  
(Date seen by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 15 19 47 at 10 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Jan 1 19 47 to Aug 15 19 47

and that I last saw him alive on Aug 15 19 47

Immediate cause of death \_\_\_\_\_ DURATION \_\_\_\_\_

Chronic Valvular

Due to Stenosis of the heart

Due to \_\_\_\_\_

Other conditions Patent. Sclerosis

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

\_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE Dr. H. H. H.

M. D. or other

Address Cherryville Date signed 8/18/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

07322

92d

RECEIVED  
AUG 26 1947  
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County... Queen Anne'sCity or town... Centerville  
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Queen Anne'sCity or town... Centerville  
(If outside city or town limits, write RURAL and give nearest town)Street No. ....  
(If rural, give LOCATION)

2.(a) If veteran, name war.

## 3. (a) FULL NAME

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

9. Birthplace

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

18. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

47

Elin Armstrong

Regist

Address

Date signed

8/25-47

Regist

Address

Date signed

8/25-47

## MEDICAL CERTIFICATION

20. DATE OF DEATH... Aug 23-1947 at 6:25 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug 23-1947

Immediate cause of death

DURATION

Carcinoma of uterus  
Due to metastasis to liver

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operation

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... No Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Harry Fisher

M. D. or other

Address

Date signed

8/25-47

Regist

Address

Date signed

8/25-47

Regist

Address

Date signed

8/25-47

Regist

RECEIVED  
SEP 5 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07324

Reg. Diat. No. 61251

## 1. PLACE OF DEATH:

County Bergen Anne'sCity or town Barclay  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 6 yrs.

Hospital, institution, or street address where death occurred:

How long in hospital or institution? ✓

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County CarolineCity or town Barclay  
(If outside city or town limits, write RURAL and give nearest town)Street No. \_\_\_\_\_  
(If rural, give LOCATION) ✓2.(a) If veteran, name war ✓

## 3. (a) FULL NAME

Clifton William Brown

## 3. (b) Social Security Number

712-12-3837

## 4. Sex

Male

## 5. Color or race

Col.

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Emma

## 7. Birth date of deceased (mo., day, yr.)

June 7 19016. (c) If alive, give age 37 years

## 8. AGE:

Years 46 Months 1 Days 26 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Barclay Queen Anne's Md  
(Town, county, and state)

## 10. Usual occupation

Grocery

## 11. Industry or business

Andrew Johnson

## 12. Name

Maryland

## 13. Birthplace

E. L. Woodley

## 14. Maiden name

Md.

## 15. Birthplace

Emma Brown

## 16. Informant

Barclay

## 17. Burial

Barclay

## 18. Funeral director

P. B. Rawlings

## 19. Date rec'd by registrar

Aug 5 1947 L. M. Pippin Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 2 19 47 at 1:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from full 19 45 to Aug 2 19 47and that I last saw him alive on Aug 17 19 47

## Immediate cause of death

Death Cardiac Deletation

## Due to

Chronic Myocarditis

## Due to

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

Date of op. \_\_\_\_\_

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_  
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Manner of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

## 23. SIGNATURE

C. M. Pippin M. D. or other Fuller, Md. Date signed 8/4/47

RECEIVED  
AUG 27 1947  
BUREAU V.E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07325

Reg. Dist. No. 61-251

## 1. PLACE OF DEATH:

County Queen Anne  
 City or town Sudlersville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death? 8 days  
 Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Queen Anne  
 City or town Sudlersville Rural  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No. \_\_\_\_\_  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sallie Carey

## 3. (b) Social Security Number

4. Sex F 5. Color or race W. 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Willie Carey7. Birth date of deceased (mo., day, yr.) July 10, 1891 6. (c) If alive, give age 67 years8. AGE: Years 76 Months 4 Days 14 It less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Sudlersville Queen Anne, Md  
(Town, county, and state)10. Usual occupation Housewife

## 11. Industry or business

12. Name Bey-man Craynor13. Birthplace Md.14. Maiden name Mo. Record15. Birthplace Mo. Record16. Informant Willie CraynorAddress Sudlersville Md.17. Burial Date thereof Aug. 26, 47  
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory WaldensLocation Near Sudlersville Md.18. Funeral director Raymond B. RawlingsAddress Summers Md.19. 8/26 19 47 S. M. Pippin  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 24 19 47 at 11:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from June 19 46 to Aug 24 19 47 and that I last saw him alive on Aug 24 19 47Immediate cause of death distended abdomen DURATION 2 daysDue to Large Ventral HerniaDue to Chronic myocarditisOther conditions Similarity

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_ Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE C. H. Upchurch M. D. or otherAddress Lyndhurst Md. Date signed 8/25/47



REC'D

OCT 2 1947

BUREAU



# MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

1. PLACE OF DEATH: Queen Anne  
County Brownsville  
City or town Brownsville  
(If outside city or town limits, write RURAL and give nearest town)  
How long in above place of death?  
Hospital, institution, or street address where death occurred:  
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:  
(For newborn infants give residence of mother)  
State MD County Queen Anne  
City or town Brownsville  
(If outside city or town limits, write RURAL and give nearest town)  
Street No. Brownsville  
(If rural, give LOCATION)  
2.(a) If veteran, name war

3.(a) FULL NAME Wm Clayton

3.(b) Social Security Number

4. Sex Male 5. Color or race col 6.(a) Single, married, widowed, or divorced Widower

6.(b) Name of husband or wife Rizzie Clayton

7. Birth date of deceased (mo., day, yr.) Aug 18 - 1888

8. AGE: Years 58 Months 11 Days 8 If less than one day  
hrs. min.

9. Birthplace 2 A Co Md.  
(Town, county, and state)

10. Usual occupation Laborer

11. Industry or business Don't know

12. Name Don't know

13. Birthplace Tennie Sullivan

14. Maiden name 2 A Co Md.

15. Birthplace Bentley

16. Informant Bentley

Address Centerville Md

17. Burial Date thereof Aug 12 - 47  
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Brownsville

Location Brownsville Md

18. Funeral director Edgar J Lane

Address Church Hill

19. 8-12- 19 47 Elie Armstrong  
(Date rec'd by registrar) Registrar

### MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 8 19 47 at

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

and that I last saw him alive on Aug 1

Immediate cause of death Chronic interstitial nephritis

Due to (Bright's disease)

Due to

Other conditions Organic heart disease

(Include pregnancy within 8 months of death)

Major findings of operations

Antopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide no Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE W. Henry Fisher M. D. or other

Address Centerville Md Date signed 8/12-47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The certificate is especially important. Physicians: please write the causes of death clearly and legibly.

07326

1310

RECEIVED

AUG 14 1947

BUREAU V A

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 251

07327

93d

## 1. PLACE OF DEATH:

County 99City or town 99 Banday Ind  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 124Hospital, institution, or street address where death occurred:  
—How long in hospital or institution? —

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Ind County 99City or town near Banday  
(If outside city or town limits, write RURAL and give nearest town)Street No. —  
(If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

## 3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced Married6. (b) Name of husband or wife Alc. Fater6. (c) If alive, give age 74 years7. Birth date of deceased (mo., day, yr.) Aug 15, 18968. AGE: Years 71 Months 1 Days 30 If less than one day  
hrs. min.9. Birthplace Hungary  
(Town, county, and state)10. Usual occupation H.W.

11. Industry or business

12. Name Joseph Fater13. Birthplace Hungary14. Maiden name Husky Huetis15. Birthplace Hungary16. Informant Alc. FaterAddress Banday Ind17. Burial Date threat Aug. 20, 47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Temple HillLocation Temple Hill Ind18. Funeral director Edgar L. LaneAddress Church Hill Ind19. Aug 19 19 47 E. L. Lane  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 17 19 47 at 29 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 17 19 47 to Aug 17 19 47  
and that I last saw him alive on Aug 17 19 47

Immediate cause of death

DURATION

Cerebral HemorrhageDue to Cerebral Arterial SclerosisDue to Chronic Myocarditis

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE C. D. Fater

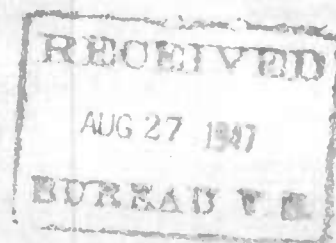
M. D. or other

Address Banday Ind Date signed 8/19/47

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07328

213

## 1. PLACE OF DEATH:

County Queen Anne'sCity or town Chester (Rural)  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen Anne'sCity or town Chester Rural  
(If outside city or town limits, write RURAL and give nearest town)

Street No.

(If rural, give LOCATION)

2.(a) If veteran, name war Spanish-American

## 3. (a) FULL NAME

Ludford C. Jones Sr.

## 3. (b) Social Security Number

None

## 4. Sex

male

## 5. Color or race

white

## 6.(a) Single, married, widowed, or divorced

married

## 6.(b) Name of husband or wife

Gertrude Neal JonesB.(c) If alive, give age 67 years

## 7. Birth date of deceased (mo., day, yr.)

Oct 5, 1877

## 8. AGE:

69 Years10 Months- Days

If less than one day

- hrs.- min.

## 9. Birthplace

Elizabeth City N.C.  
(Town, county, and state)

## 10. Usual occupation

retired

## 11. Industry or business

FATHER

## 12. Name

Charles Radcliffe Jones

## 13. Birthplace

Ida.

MOTHER

## 14. Maiden name

Alphena P. Jones

## 15. Birthplace

Elizabeth City N.C.

## 16. Informant

Gertrude Neal Jones

## Address

Chester Md.

## 17.

Burial

(Burial, cremation, or removal, Which?)

Date thereof 8/9/47

(month) (day) (year)

## Cemetery or crematory

Loudon Park Cem.

## Location

Baltimore Md.

## 18. Funeral director

Wm. J. Tickner & Sons Inc.

## Address

North & Pa. Aves. Balto. 17, Md.

## 19.

Aug 7, 1947

(Date rec'd by registrar)

Elizabeth Hostler

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug 5, 1947, at 10 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 15, 1947, to Aug 5, 1947.and that I last saw him alive on Aug 5, 1947.

## Immediate cause of death

Coronary thrombosis andDue to occlusionangina pectorisDue to sclerosis of coronary

arteries.

Other conditions myocardial infarction, tachycardia

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

## 23. SIGNATURE

Theodor Sattelmaier

M. D. or other

Address StevensvilleDate signed 8/5/47.

RECEIVED  
JUL 11 1947  
BUREAU V.A.



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No.

07329

253

## 1. PLACE OF DEATH:

County..... Queen Anne  
 City or town..... Dominion - Kent Island  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?..... 37 yrs  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?.....

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... MD County..... Queen Anne  
 City or town..... Dominion  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) if veteran, name war..... ☒

## 3. (a) FULL NAME

William T. Jurod

## 3. (b) Social Security Number

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

Married

## 6. (b) Name of husband or wife

Annie Mae Jurod

## 7. Birth date of

deceased (mo., day, yr.)

November 30 - 1881

## 8. (c) If alive, give age

59 years

## 8. AGE:

Years

Months

Days

If less than one day

6591

hrs.

min.

## 9. Birthplace

Netuxes - Md  
(Town, county, and state)

## 10. Usual occupation

lecturer

## 11. Industry or business

## FATHER

## 12. Name

Do not know

## MOTHER

## 13. Birthplace

Netuxes

## 14. Maiden name

Netuxes

## 15. Birthplace

Netuxes - Md

## 18. Informant

Mrs Irene Cole

## Address

Centreville, Md

## 17.

(Burial, cremation, or removal. Which?)

## Date thereof

Sept 3 - 47  
(month) (day) (year)

## Cemetery or crematory

Stevensville

## Location

Stevensville, Md

## 18. Funeral director

Barton Bros

## Address

Centreville - Md

## 19.

(Date rec'd by registrar)

Sept 347Elizabeth H. H. H.

Registrar

## MEDICAL CERTIFICATION

## 20. DATE OF DEATH

August 31 1947, at 6:30 P.M.

## 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 27 1947, to Aug 31 1947,  
and that I last saw him alive on Aug 31 1947.

## Immediate cause of death

Cerebral hemorrhage

## DURATION

Aug 27  
1947

## Due to

Arteriosclerosis  
(cerebral)

## Other conditions

(Include pregnancy within 3 months of death)

## Major findings of operations

## Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

## 22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

## Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

## Means of injury

Injured at work?

## 23. SIGNATURE

Theodor Sattelmaier M.D.

M. D. or other

## Address

StevensvilleDate signed 8/31/47



RECEIVED  
SEP 5 1947  
BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 201-51

## 1. PLACE OF DEATH:

County Baltimore Anne Co.City or town Mar. @ Leesylvania  
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 5 months

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County KentCity or town Leesylvania  
(If outside city or town limits, write RURAL and give nearest town)Street No. md  
(If rural, give LOCATION)

2(a) If veteran, name war.

## 3. (a) FULL NAME

Homer Nelson King

## 3. (b) Social Security Number

217-05-2292

## 4. Sex

Male

## 5. Color or race

White

## 6. (a) Single, married, widowed, or divorced

married

## 6. (b) Name of husband or wife

Bessie Jewel6. (c) If alive, give age 52 years

## 7. Birth date of

deceased (mo., day, year) October 31, 1897

## 8. AGE:

Years 49 Months 10 Days 19 If less than one day  
hrs. min.

## 9. Birthplace

Kennedysville  
(Town, county, and state)

## 10. Usual occupation

Carpenter

## 11. Industry or business

FATHER

## 12. Name

William H. King

## 13. Birthplace

Kennedysville

MOTHER

## 14. Maiden name

Theresa King

## 15. Birthplace

Kennedysville

## 16. Informant

Miss Bessie King

## Address

Kennedysville

## 17. Burial

(Burial, cremation, or removal, Which?) Burial Date thereof Aug 31, 1947  
(month) (day) (year)

## Cemetery or crematory

Chester Cemetery

## Location

Chester town, Md.

## 18. Funeral director

B. R. Fellows

## Address

Still Pond, Md.

## 19. Date

Aug 21, 1947  
(Date read by registrar)Registrar J. M. Clark

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 18, 1947 at 3.30 P21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Feb. 7, 1947 to Aug 19, 1947and that I last saw him live on Aug 19, 1947Immediate cause of death Coronary Thrombosis DURATION 6 mo

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Frank W. SmithAddress Chester town, Md. Date signed Aug 18, 1947

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AUG 26 1947

BUREAU 78

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1600

07331

## CERTIFICATE OF DEATH

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County..... Queen Anne  
 City or town..... near Centerville  
 (If outside city or town limits, write RURAL and give nearest town)  
 How long in above place of death?  
 Hospital, institution, or street address where death occurred:  
 How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)  
 State..... Md. County..... Queen Anne  
 City or town..... near Centerville  
 (If outside city or town limits, write RURAL and give nearest town)  
 Street No.....  
 (If rural, give LOCATION)  
 2.(a) If veteran, name war.....

## 3. (a) FULL NAME

Rayfield Roberts

## 3. (b) Social Security Number

4. Sex

Male

5. Color or race

Col

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Aug 11 - 1947

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

2

hrs. min.

9. Birthplace

2. a Co. Md.

(Town, county, and state)

10. Usual occupation

none

11. Industry or business

FATHER

12. Name

Rayfield Scott

13. Birthplace

Md.

MOTHER

14. Maiden name

Emma Roberts

15. Birthplace

Md.

16. Informant

Address

Rayfield Scott (Father)Wye Mills Md

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 14 - 47

Cemetery or crematory

Brownsville

Location

n. Centerville Maryland

18. Funeral director

Address

Boston TeroCentreville, Maryland

19.

(Date rec'd by registrar)

8-13-47Elmer Armstrong

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH

Aug 13 1947 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Aug 13 1947 to Aug 13 1947

and that I last saw him/her alive on..... 19.....

Immediate cause of death

DURATION

Infantile Coarctation

Due to

(Birth injury likely)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. ....

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of .....

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

W. Henry Fisher

M. D. or other

Address

Centerville Md.Date signed 8/14-47

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

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AUG 26 1947

BUREAU

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

Reg. Dist. No. 07332  
253

## 1. PLACE OF DEATH:

County Queen AnneCity or town Rural Chester

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 40 yrs

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Rural Chester

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

James Daniel Sewell

## 3. (b) Social Security Number

4. Sex M 5. Color or race C 6.(a) Single, married, widowed, or divorced Widowed6.(b) Name of husband or wife Janie Sewell

5.(c) If alive, give age \_\_\_\_\_ years

7. Birth date of deceased (mo., day, yr.) August 6, 18748. AGE: Years 73 Months \_\_\_\_\_ Days 13 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Chester, Maryland  
(Town, county, and state)10. Usual occupation Laborer

11. Industry or business \_\_\_\_\_

12. Name James Henry Sewell13. Birthplace Stevensville, Md14. Maiden name Mary Maria Sanders15. Birthplace Chester, Md.16. Informant Cornelius SewellAddress Stevensville Md.17. Burial Date thereof Aug 22 - 47  
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory ChesterLocation Chester road18. Funeral director Chapman & SonsAddress Church Hill Md19. Aug 23 19 47 Elizabeth Porter  
(Date read by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 19 19 47 at 9 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 46, to August 19 19 47and that I last saw him alive on August 17 19 47

Immediate cause of death \_\_\_\_\_

Uremia DURATION 2 daysDue to Cystitis 1 wkDue to Benign Prostatic Hypertrophy 2 yrs

Other conditions \_\_\_\_\_

(Include pregnancy within 8 months of death)

Major findings of operations \_\_\_\_\_

Date of op. \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William C. Howe MDAddress Queen Anne Md Date signed Aug 20, 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.



RECORDED

AUG 27 1947

BUREAU OF



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

## CERTIFICATE OF DEATH

07333

Reg. Dist. No. 252

## 1. PLACE OF DEATH:

County... Queen Anne's  
 City or town... Croftsville  
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 48 years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Queen Anne's

City or town... Croftsville  
 (If outside city or town limits, write RURAL and give nearest town)

Street No. ....  
 (If rural, give LOCATION)

2.(a) If veteran, name war

## 3. (a) FULL NAME

Sarah Hayden Slummer

## 3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

6.(b) Name of husband or wife

Milton B Slummer

6.(c) If alive, give age..... years

7. Birth date of

deceased (mo., day, yr.)

March 20 - 1873

8. AGE:

Years

Months

Days

It less than one day

7455

hrs.

min.

9. Birthplace

Swones Chapel Del.

(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

MOTHER FATHER

12. Name

Daniel Hayden

13. Birthplace

Delaware

14. Maiden name

Miriam Pippin

15. Birthplace

Delaware

16. Informant

Milton B Slummer

Address

Croftsville

17.

(Burial, cremation, or removal. Which?)

Date thereof

Aug 27 - 47

(month) (day) (year)

Cemetery or crematory

Silver Brook

Location

Wilmington Del

18. Funeral director

Barton Bros

Address

Croftsville Maryland

19.

(Date rec'd by registrar)

8-26-47Elin Armstrong

Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH Aug. 25 - 1947 at 5 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

April 1 - 1947to Aug 25 - 1947and that I last saw him alive on Aug 21 - 1947

Immediate cause of death

Angina Pectoris

Due to

(Sudden)

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

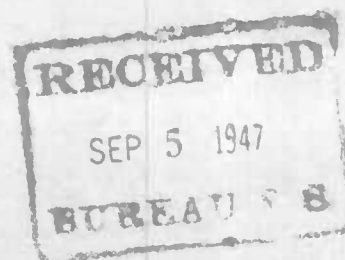
W. Henry Fisher

Address

Croftsville Md

M. D. or other

Date signed 8/26/47





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SEP 5 1947

BUREAU 68

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

526

07335

## CERTIFICATE OF DEATH

Reg. Dist. No. 254

## 1. PLACE OF DEATH:

County Queen AnneCity or town Groasonville

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 46

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Queen AnneCity or town Groasonville

(If outside city or town limits, write RURAL and give nearest town)

Street No. \_\_\_\_\_

(If rural, give LOCATION)

2.(a) If veteran, name war \_\_\_\_\_

## 3. (a) FULL NAME

John Washington Windsor

## 3. (b) Social Security Number

NONE4. Sex M 5. Color or race W 6. (Single, married, widowed, or divorced) Married6. (b) Name of husband or wife Mary Catherine Windsor6. (c) If alive, give age 73 years7. Birth date of deceased (mo., day, yr.) March 13, 18658. AGE: Years 82 Months 4 Days 28 If less than one day \_\_\_\_\_ hrs. \_\_\_\_\_ min.9. Birthplace Somerset County, Md  
(Town, county, and state)10. Usual occupation Waterman

## 11. Industry or business

12. Name Isaac Windsor13. Birthplace Somerset County, Md14. Maiden name Susie Ford15. Birthplace Somerset County, Md16. Informant Mrs. Mary C. WindsorAddress Groasonville, Md17. Burial Date thereof Aug 13-47  
(Burial, cremation, or removal) (month) (day) (year)Cemetery or crematory CentervilleLocation Centerville Maryland18. Funeral director Barton BrosAddress Centerville Maryland19. Aug 11 19 47 H. M. Aledridge  
(Date rec'd by registrar) Registrar

## MEDICAL CERTIFICATION

20. DATE OF DEATH August 10 19 47 at 10:55 P M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

February 1 19 47 to August 11 19 47and that I last saw him alive on August 10 19 47Immediate cause of death Carcinoma of Bladder

DURATION

1 yr.

Due to \_\_\_\_\_

Due to \_\_\_\_\_

Other conditions Atrophic Kidney - int.Arteriosclerosis - generalized

(Include pregnancy within 3 months of death)

Major findings of operations \_\_\_\_\_

Autopsy results \_\_\_\_\_

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide \_\_\_\_\_ Date of \_\_\_\_\_

Where did injury occur? \_\_\_\_\_ (City or town) \_\_\_\_\_ (County) \_\_\_\_\_ (State)

Injured at home, farm, industry, public place (where?) \_\_\_\_\_

Means of injury \_\_\_\_\_ Injured at work? \_\_\_\_\_

23. SIGNATURE William C. Lane MD

M.D. or other

Address Queensdown Md Date signed Aug 10, 1947

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

AUG 14 1947

BUREAU V &